DAIL C4C Stakeholder Meetings
October 14, 2010
Skylight Conference Room

	QUESTIONS	ANSWERS
	Challenges for Change Projects led by DAIL	
Project 1 – LTC	**Performance Based Contracting & Reimbursement Rates**	
Beth Stern, AAA	**1.** Can you provide a list of grants and contracts that this affects?	Legislative direction is broad, encompassing all of state government and all of DAIL. Status of grants and contracts within the Division of Disability and Aging Services (DDAS): Performance/outcome measures in place: • ARIS • SCSEP • TBI HCBS services (individual outcome measures) • DS HCBS services (individual outcome measures) • DS Bridge services • DS supported employment • Numerous contracts (e.g. consumer surveys, CFC independent evaluation) Performance/outcome measures under near-term discussion/development: • AAA case management • AAA nutrition • Adult Day • DA/SSA Grants (including DS, MH and SA service components) • HASS • Home sharing • VCIL home-delivered meals
Janet Cramer, Adv Bd	**2.** CFC extension with no substantial changes; is this allowed under CFC?	If performance based contracting does not substantially affect existing payment mechanisms under Choices for Care, it would not constitute a substantial change and is allowed. If other changes to reimbursement (phase 2) substantially affect existing payment mechanisms under Choices for Care, it may constitute a substantial change and require an amendment.
Diane Novak, DAIL Adv Bd	**3.** Phase 2 begin date?	Anticipated start date 12/10-5/11.

Barb Prine, VLA DD Law Project	**4.** Urge the burden of "bean counting" doesn't interfere with the contractor's ability to deliver services. She currently works under 7 grants and the quarterly reporting requirements are very burdensome	The department recognizes that outcome and performance measures need to be manageable as well as meaningful. The goal is to assure high quality direct services with the lowest administrative burden.
Lynn, Adult Day	**5.** Outcomes/measures – how were these identified?	The outcomes and initiatives in the biweekly report document were defined by the Legislature in Challenges for Change legislation (H.66, H.789, H.792). The measures were drafted internally and are subject to change. Outcome and performance measures for individual contractors and grantees are defined in collaboration with the grantees and contractors.
Peter Cobb, VAHHA	**6.** On estimated savings, since we're a couple months into the FY have we saved anything so far?	As of late August, cash expenditures for one month of Choices for Care were available. While the expenditures for one month are approximately $1 million less than estimated, this single month does not represent a valid or reliable measure of costs avoided ('savings').
	7. How is increased choice connected to performance based contracting?	While performance based contracting in and of itself does not increase consumer choice, a tiered funding mechanism for home based services could give more flexibility and choice to consumers. In Phase 2 of this project we will develop tiered payment system endeavoring to connect increased consumer choice and flexibility for home based services to performance based contract payment mechanisms for them.
Beth Stern, AAA	**8.** Is there any way to measure increases in the costs to accommodate the increased services needed in the community (e.g. home delivered meals).	Currently Vermont has no feasible method of tracking costs associated with specific individuals across all services and funding sources. Several studies have concluded that the average costs of serving people in the community are lower than the costs of serving people in nursing homes.
Amy Caffry, parent	**9.** It's hard to figure out what money is coming from where because everything is done in isolation by departments that do different things for my son. I would like to know what my child costs per year, to lower that number: AHS, DOE, aggregate costs. It's hard for me to have creative thoughts when I can't get a full picture, to understand what can be consolidated.	We recognize that the array of state and federal budgeting and financial management processes do not currently support a simple summary of costs for any individual. Some of this also may come from work in the Integrated Family Services Challenges.

	10. If you do a survey – it would be good to ask consumers what they think should be cut out as not needed.	We are open to suggestions from consumers about what services they would like to eliminate as not needed.
Sue Chase, Adult Day	**11.** What are you thinking about early intervention and prevention	In the context of this project, existing services provided under current grants and contracts (Phase 1) and Choices for Care services and funding (Phase 2). This project does not create new funding or services for early intervention or prevention.
Michael Sirotkin	**12.** Can you indentify what cost-saving ideas were in the budget and not accepted by the Legislature; explain what was rejected. C4C was NOT intended to backfill areas that the legislature had rejected under the guise of challenges.	Two DAIL Challenges ideas were rejected or no action was taken by Legislature. • Proposal: Convert Vermont's last six-bed Intermediate Care Facility to an Enhanced Residential Care Home, reducing regulatory requirements while reducing expenditures. No legislative action. • Proposal: Strengthen estate recovery and maximize private contributions to Long Term Care Medicaid. Not adopted by the legislature. The Department will work on a summary of items that were backfilled by the legislature after originally listed as a reduction in the Governors Recommended budget last year.
Project 2 - LTC	**Adult Family Foster Care**	
Sue Chase	**13.** I'm curious about the financing of this. We tried to do this in Franklin County and we met roadblocks because we didn't have the incentives/special housing stipend that DDS has.	Existing Choices for Care funding would be used to support the costs of services with individuals paying their own costs of room and board. This is comparable to financing of Enhanced Residential Care and nursing homes.
Laura Pelosi, Nursing Home Association	**14.** Pay close attention to cost: economy of scale even with RCH; concern is that we'll further undermine our current service options (NH, RCH) by stretching existing dollars further.	Comment noted.
Janet Cramer	**15.** VA has developed a similar program for Vets to meet combination of residential and medical care.	Comment noted.
Lynn, Adult Day	**16.** Terrible name, disrespectful – call it something different.	Comment noted. DAIL welcomes any and all suggested alternatives as we are actively discussing other names for this service. This term was created by CMS and has some national use.

Karen Topper, GMSA	**17.** Applaud you for considering doing this for this population; if you don't save $1.8M by July 1, 2011 will other DAIL programs be subject to cuts if target not reached.	We anticipate that if adequate savings are not achieved in one program cuts in other programs and services are possible.
John Barbour, AAA	**18.** The document refers to a project charter and draft white paper- when will these be available?	We will endeavor to provide a draft description of the proposal for stakeholder review by the middle of October, with the aim to have proposal finalized by the end of this calendar year.
	19. Why isn't the Addison County model "the" one that we will consider	We are looking at range of models, considering a gradation of types of family care settings. Home inspection; structured room and board agreements; and a tax free daily stipend may be needed
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	20. What population are we looking to serve? Residential care and ACCS is already stretched and underfunded. Cost is a significant issue especially if we get into 24/7 model ($6 per hour nursing home incl staffing and room and board). Regulatory oversight is very important. From a facility perspective this is very expensive and you are creating an unequal playing field for those who are regulated. There is also concern about the lack of DLP oversight of residential care homes.	Any individual who is enrolled in Choices for Care would be eligible to access this service setting. Regulatory oversight would be driven by the design elements of the final product.
	21. Is this DD population, or MH? I think in order to figure out whether something will cost less we need to consider that at $6 per hour more innovation is not feasible. There isn't any one size fits all for anything. We should keep in mind what is best for consumer. While our number one concern is that we save money, we also need enough options to meet different needs. Looking at people who are looking at long-term care we should work backward to determine what makes the most sense. Start with your goal in mind.	The department will be looking at this initiative within the long-term context of our 4 year State Plan on Aging in place. The LTC Policy Committee is another forum, The target population for which this option is being proposed is for individuals who are eligible for Choices for Care; that is, individuals who meet the clinical standard for Nursing Home level of care and financial standard for long term care Medicaid.

	22. Are we assuming that DD model is what you are considering replicating? What would make this a more cost effective option?	We have a different range of preferences, needs and funding. It's cost effective for us as a whole to use resources that way because not everyone needs that level of oversight and care. We look at ERC and that is our most cost-effective system but we are not enough to pay.
	23. HomeShare (6 counties) does the opposite of adult foster care and we provide bartering arrangement for people to move in with the elder and stay in their home. Live-in care program (Chittenden County only) – is also a match bring in a live-in care person with a salary and room and board.	Comment noted.
	24. Adult Day plays a role here too. The live-in agreement includes that a person can participate in adult day as much as they want. I'm worried that we'll create problems for existing services.	We will be cognizant of how service settings will impact on current providers. That must be balanced with developing service settings and options that best meet the needs of the consumers as well.
	25. I keep my son at home. It seems like AFFC allows people to stay with their families. I believe it's very important to preserve the home-based settings. The more you empower me to do myself the less I cost the system.	The goal for Choices for Care is to allow individuals to receive the services in the setting of their choice and appropriate to their need.
	26. I echo that it's very important to keep in-care home as an option. I share the concern that we not draw resources from fragile residential care homes. I have been envisioning that we'd make Addison County model state-wide. I'm concerned we not broaden things too much without adequate supports and oversight because of inadequate oversight.	Comment noted.
	27. I family-manage a developmental home for my son. Because of 2007 change, I have to pay federal minimum wage of $8.06/hour - Is the AFFC a developmental home under CFC or under DS?	We are discussing CFC waiver. We should learn from Addison County model and the DS waiver and HomeShare and other states, weigh pros and cons what makes sense for expanding Adult Family Foster Care. We don't know what the model will look like yet. We're exploring the pros/cons and recommendations.

	28. I've had the privilege as a public guardian to work for both CFC 24-hour folks and DDS developmental homes. I have views on both approaches for keeping people in the community. We can get bogged down in the numbers but we need to think about the quality of life that we allow people to have. What will "we" do today vs. "bingo". If we can do it affordably I would hope we'd create it.	Choices for Care provides long term care services to elderly or physically disabled individuals in the setting of their choice: home and community, residential care or nursing facility. Long term care services are personal care services which assist an individual to maximize their functioning in meeting their daily care needs.
	29. Worry that we are creating a whole new budget, whole new staff with whole new system. Why not give support to the systems already in place? This is not the time in the budget to start anything new.	Our intention is to add a service delivery setting to our current range of service settings in response to what we are hearing from the Choices for Care renewal process. We are looking to expand the menu of service settings not adding more people beyond those who are eligible, nor adding more funding.
	30. I am not suggesting a new program. Why not pilot a couple of ideas which shouldn't cost a lot of money and we can get an idea on if/how it works? I'm not sure DD works for everyone. Why not pilot paying families? C3 pilot was very successful from the consumer side. When I get together with parents, they want the same thing: fun, family, friends, communities, a senior gated intentional communities in congregate settings may work for some people. Sometimes it's lonely for people in developmental homes. Community means different things to different people.	This idea will be brought to the workgroup for consideration. Choices for Care, in the community and home-based settings, currently allows for family members, including spouses, to be paid to provide personal care services. There are as many options for models as there are preferences.
	31. I'm aware that there are some places where people are there and blossoming and others are in a place who looks at it as a paycheck. I worry about the oversight. The CFC has excellent oversight.	Oversight will be a consideration in the deliberations for other options.
	32. We are looking at this almost from the experience of the person needing care. Our rules were no more than 2 people for family. In a way this expands the care-giving and non-professional care. Family care-giving is needed. It may	The threshold for triggering licensing and protection is more than 2 people.

		be an opportunity to expand this pool of caregivers. It's very important to bring them into mutual support groups. I don't see this as competing with HomeShare or Residential Care Home. I think up to 6 people in a home may be a reason that there were problems.	
	33.	It bothers me that we say residential care homes are cost-effective when it's so underfunded. I don't think it's right to create more systems to fail if we underfund them. I look back at the original project: "to expand to full time services, similar to a developmental home." It sounds like it requires the work group to look at the benefits and drawbacks and bring back to advisory board of what was explored.	The workgroup will examine all aspects of the model, including costs and benefits and will report back to the advisory board on their results.
	34.	SASH is looking at trying to meet this need. Friends are looking at a condo in the middle of Burlington. For example if they could have a continuum of care that helped people stay in a community. My mother lives with me in summer. She's 93 years old. Community piece is really important and serving people there is critical.	Comment noted.
	35.	The term "foster" care by other States means tax free stipend; Adult Foster Care in Washington – average of 15 residents per home - need to look at how a state defines number of residents; Over 20 years there's been an expansion from personal care services (PCS) to many more choices; 60% PCS are consumer and surrogate directed, not agency directed; Today you can hire spouse, family and others in CFC; People in Flex Choices could purchase this now.	Comment noted.
	36.	Why aren't more people using flexible choices?	Flexible Choices is one of many different options. Choices for Care participants have in getting their needs met. Participants are able to choose the option that best fits their needs and desires.

	37. There are settings where people are more successful one on one, versus group setting	Comment noted.
	38. What is the budget and projected number of people for this?	We are expanding the menu, not more people, not more budget.
Project 3 - LTC	**Presumptive Eligibility**	
Janet Cramer	**39.** How does this offer an opportunity for savings?	Currently, some home- and community-based services (HCBS) providers are unable to start CfC services while eligibility is still being determined due to the financial risk a person may be found ineligible and they will not get paid for services provided. Conversely, more nursing facilities are willing to accept people and start providing services even while eligibility is determined. So, it is thought that there are a number of people who choose nursing home because they need services right away and are able to receive these services more quickly than HCBS. By implementing a simplified eligibility process we will be granting Medicaid sooner for certain individuals and the provider is assured that it will be reimbursed. Consequently, it is assumed that more people will be able to choose and receive home- and community-based services (HCBS) more quickly and will choose them over nursing facility services, which are generally more costly. The rationale behind this is that even if HCBS services are started sooner, in the long run this will generate savings in that more people are able to choose and receive HCBS.
Amy Caffry	**40.** It's really hard to look at change and say that we're going to see "this much" savings. It's really short-sighted to NOT describe savings for each year.	We recognize that thoughtful long-term planning and estimates are helpful. We are doing our best to be thoughtful in light of the immediate budget pressures. With respect to this initiative, as our planning progresses we plan to describe potential savings by estimating the number of persons who may be able to go through a simplified eligibility process and may therefore then choose HCBS where they otherwise would have chosen nursing homes, looking at average HCBS costs as compared to nursing home costs.
Peter Cobb	**41.** Clearly a high priority in the legislature, do we have a target date for implementation?	Not yet. We still need to iron out the logistics of how the simplified process will work and what needs to happen not only at DAIL, but at the

			Department for Children and Families (DCF) Economic Services Division (ESD) and Hewlett Packard (HP), the business that processes the claims for billing from providers. Once we have identified all of the steps we will be able to establish a target date for implementation. We are targeting late October to have a proposal for implementation for input from stakeholders.
Barbara Prine	**42.**	How does the proposal save money? Understand the theory that if you are able to start services sooner, you might be able to prevent the individual from getting worse.	This may be the case for some people, but not all. This process would be applicable only to those who already have been found clinically eligible for CfC. Please see response in question #19 above for the rationale behind savings in this area.
Sue Chase	**43.**	If a person is ultimately found ineligible, who pays?	The State will cover the cost of services provided. In the highly unlikely event that a person is found ineligible Payment for CfC services will stop at that point and providers will be notified.
Ken Gordon, AAA	**44.**	26. Concerned that adding additional burden to DCF at a time when they appear to be overwhelmed by existing workload demands and system improvements.	We understand the concern. Our hope is that implementing this simplified process may help DCF in identifying applications that are straightforward and can be prioritized.
John Barbour	**45.**	27. Cost savings – throw resources to DCF to get people into services sooner. Is there a way to get people services sooner?	We do not have resources at this point to send to DCF. Regardless, the goal of this proposal is aimed at starting services sooner by implementing a simplified eligibility determination process.
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	46.	Will people going into nursing homes be granted eligibility while services being determined?	Since nursing homes are included in Choices for Care (CfC), yes, people going in to nursing homes who meet the simplified eligibility criteria will be granted Medicaid and provided services while the full financial eligibility is being determined. It is important to remember that participants admitted to a nursing home within the first 30 days of being on CfC will be subject to the transfer of assets review to determine if a penalty period should be imposed (Medicaid look- back). If resources have been given away within 5 years of needing nursing home care, the person may eventually be found ineligible. All applicants sign an attestation confirming that the information reported on their Medicaid application is accurate.

Project 4 - LTC, DDS	Individuals served by DAIL with co-occurring mental health needs.	
Ann Bakeman	**47.** Is this a growing population of people? What is the percentage of people that have these dual issues?	This is a growing cohort. In any population there is a percentage diagnosed with mental health needs. Add to this the aging demographics of the United States and Vermont in particular and it is clear that more and more individuals need these combined services. It is easy to track the aging population because we have specific data such as birthdates. The population of individuals with mental health needs is very difficult to track without such a concrete marker. It is difficult to give specific percentages of the population that fit this description.
Barb Prine	**48.** Two needs/holes in system – there should be an extra "on top" funding mechanism – a pop up funding for more "extra special care procedures" – some part of the system has to recognize the extra costs. Training is essential for DMH to understand medical; medical needs to understand CRT.	Both comments are noted.
Beth Stern, AAA	**49.** How does the Elder Care Clinician Project (ECCP) fit in with this initiative?	The specifics are not yet developed but the ECCP is recognized as having a role in this initiative.
Marie, LTC Ombuds	**50.** Working them in for people who are new; don't forget people who are in the system already, and have developed MH issues in the nursing home	Comment noted
Laura Pelosi	**51.** It's important to find some assistance for people in nursing home who have mental health issues. Some people have skilled care needs that are not high enough for nursing home level of care, but are in the lowest 4 case mixes because hard to place due to substance abuse or mental health issues.	Comment noted.
Jeff Coy	**52.** MOU for developmental services; is there an idea to implement one single MOU ultimately?	Yes, the concept of a single, comprehensive MOU between DAIL and DMH is under consideration.

John Barbour	**53.** People who experience MH needs late in life for the first time, maybe not CRT ever, but Elder Care Clinician Project outpatient services cohort needs to be incorporated.	Comment noted.
Project 5 - DDS	**1 percent reduction to DA DDS budget**	
Barb Prine	**54.** Are there regional/agency differences in how cuts were made?	Yes. Agencies were given flexibility in how the reductions were made. Agencies' plans to address the reduction were approved by their board of directors. We will be providing a summary of cuts and impacts once we have received statements from all agencies.
	55. It would be helpful to know if there are waitlists in parts of the State for DS.	Currently we do not have people on waiting lists for DS waiver services. DS services are not an entitlement, however, and as a result funding pressure, we have had to limit services as defined in the State System of Care Plan.
	56. Are some agencies saying there are fewer people waitlisted for Flexible Family Funding?	Yes. There are fewer people on the waiting list now, than there were in June of 2010. FFF is allocated annually in July based on utilization to better meet regional needs and take families off waiting lists As of July 1, 2010, six agencies had waiting lists for approximately 50 requests for FFF.
	57. Are there regional/agency differences in how cuts were made to FFF? Are some agencies decreasing amounts of FFF that families receive?	Yes. Some agencies absorbed the FFF cut; other agencies reduced the amount families received by up to $10 per family.
Barb Prine	**58.** Since C4C was not supposed to result in reductions in services, if the 1% cut reduced services will these services need to be reinstated?	No. C4C directed that agencies "shall minimize service reductions". Though not desirable, reductions in services were allowable.
Project 6 - DDS	**New residential options**	
Jeff Coy	**59.** Are there going to be consumers or self-advocates on each one of these workgroups?	These forums are for input and we are open to getting consumer input in other ways. We welcome your suggestions on how to get consumer input for each initiative.
	60. Will consumers be able to weigh in on the ultimate decision about new residential options?	We plan to recruit self-advocates and family members to review, analyze, and make recommendations about new residential options and more cost effective service models.
Barb Prine	**61.** Vermont has a GREAT residential system, other states have HORRIBLE ones. Let's not do the race to the bottom.	Comment noted.

Amy Caffry	**62.**	Within the State System of Care Plan (SSOCP), who interprets what the words mean? E.g. "What does 'community based' mean?" It should be defined more broadly than the way the providers and State define it.	42. Definitions and guidelines for the SSOCP have been developed with stakeholder (provider, self advocate, family, advocate, etc) input.
	63.	Also, VT does a great job in some areas, but there is also a lot of "middle of the road" and it seems the families are the last to be asked. As a parent whose child will someday be an adult needing supports, I worry about a one solution system. Can parents be involved in defining more options?	Parents and families have participated actively in the development of the Vermont developmental disability system, especially from 1993 to the present.
	64.	I see a lot of states doing a lot of cool, innovative things. I wonder if there's any way for the SSOCP to be expanded.	New ideas are always welcome**.** The SSCOP can be expanded to include new service models, funding priorities, initiatives. It is developed every 3 years and updated annually based on broad stakeholder input and available resources.
Kathleen DeMerritt	**65.**	Is it possible that the SSOCP will restrict the ability to make changes to make better choices, better outcomes, and saving money?	The SSCOP (Plan) is intended to promote better choices, improved outcomes, and cost effectiveness. The purpose of the Plan is to describe the nature, extent, allocation, & timing of resources and services, including funding criteria, funding priorities, and new options. The Plan is developed with broad public input. When funding is cut or will not meet projected needs, funding priorities and service options may be changed/limited to most effectively manage reduced resources.
Anne Bakeman	**66.**	In relation to the outcomes expected from this project, will people still have their choice in their living setting arrangement to the ones they preferred. Or, will it be highly influenced by the most cost-effective option?	The most cost effective option is already required by the existing funding guidelines and choice is currently supported and promoted within this constraint.
Project 7 –DDS	**New service models for people with high-cost services**		
Amy Caffry	**67.**	We're in deep financial trouble now. In cost effectiveness, would it be worthwhile to look more long-term at feasibility cost of services?	Short term savings must be found to assure programs are sustainable in the long-term. We agree that it is preferable to look at long-term sustainability and look for opportunities to invest in economical service delivery options. We welcome

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<tr><td></td><td></td><td>specific suggestions from stakeholders to support this approach.</td></tr>
<tr><td>Barb Prine</td><td>68. Please define the group that belongs into the “high cost DDS”? What percent are “high cost” and why are they high cost? E.g. DOC/DMH “mini-teams” that work with these tough cases - depending on the reason for the high cost, perhaps we should convene other teams.</td><td>The department is currently analyzing how best to define “high cost services”. Further analysis will be completed by the department and the workgroup. We welcome stakeholder input. Some individuals who are considered “high cost” have public safety issues; some have co-occurring mental health issues; some have significant health needs.
Here is some additional context.
In FY ’09 3,734 individuals received Home & Community Based Services (HCBS; formerly known as “waiver”) or other DDS funded services (e.g. FFF, TCM, Nursing Facility Day Rehab, ICF). HCBS includes service coordination, employment supports, community supports, home supports, respite, clinical supports, crisis supports, and transportation
Our highest cost program is HCBS. In FY ’09 2,372 individuals received home & community based services (HCBS). The average annual individual HCBS cost in FY ’09 was $54,151.
The chart below provides a breakdown of the level of HCBS funding and the number of individuals served within these ranges:
Average Service Rates for People getting HCBS only
<table><tr><th>HCBS Total Annual Plan Amount</th><th>Number of People</th></tr><tr><td>< $10,000</td><td>85</td></tr><tr><td>$10,000 - $24,999</td><td>311</td></tr><tr><td>$25,000 - $39,999</td><td>390</td></tr><tr><td>$40,000 - $54,999</td><td>555</td></tr><tr><td>$55,000 - $69,999</td><td>437</td></tr><tr><td>$70,000 - $84,999</td><td>247</td></tr><tr><td>$85,000 - $99,999</td><td>116</td></tr><tr><td>$100,000 - $149,000</td><td>163</td></tr><tr><td>$150,000 - $199,000</td><td>53</td></tr><tr><td>$200,000 & over</td><td>15</td></tr><tr><td>TOTAL</td><td>2,372</td></tr></table></td></tr>
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Project 8 – DDS	Reduce cost for serving individuals who pose a public safety risk	
Sarah Launderville	**69.** How are people determined to be in the public safety group?	Approximately 200 people
Barbara Prine	**70.** Restrictions should be tied to the risk (e.g. offense with adults, should not be restricted from contact with children)	We agree. We are evaluating the reason for individual's restrictions. For example, are they tied to risk to reoffend, or to other factors.
	71. Hope the evaluation has flexibility to factor in what has happened.	The Risk Assessment will factor in what has happened.
	72. What is the timeline for evaluation and all the pieces?	We are striving to have all of the 200 Risk Assessments completed by January 2011, the analysis and draft protocol completed by March 2011.
Dixie McFarland	**73.** If the agencies were not held to the liability if re-offense happened, that would help.	Liability concerns are real and must be taken seriously. However, the problem is complex and requires further consideration.
Amy Caffry	**74.** Clarify – where does the whole VSH thing fit in?	Vermont State Hospital is not managed by DAIL. It is part of the Department of Mental Health. Currently the state hospital is not able to access Medicaid funding and is going through processes that would allow it to get Medicaid funding in the future. Additionally, The futures project at Mental Health is looking into other community alternatives to the state hospital.
Ann Bakeman	**75.** How is DOC involved in this project? Could outreach and education of DOC be done in order to help them understand the risk and re-offense, and to help with the potential cost?	DOC is not involved in this project. We will get their input for the Risk Assessments for the approximately 10 individuals who are in DS services and also under DOC supervision. DOC is aware of risk and re-offense because their levels of supervision are structured accordingly. Cost of services is managed on a case by case basis.
Janet Cramer	**76.** Is there an appeals process for a person who is determined to be Act 248/public safety	We are working on that process.
John Barbour	**77.** It would be useful to know how much we are spending on these cases. Answer with LINK to REPORT	Information regarding costs can be found in the Legislative Report on Individuals Who Pose a Public Safety Risk (February 2010) http://www.ddas.vermont.gov/ddas-publications/publications-dds/publications-dds-documents/dds-publications-other/ds-offenders-report-2009
Barb Prine	**78.** For Act 248 there is judicial review. For those who are under public	The Legislature has directed us to develop a protocol to ensure individuals do not remain in

		safety but not Act 248, and receiving OPG, we need a mechanism for other people to get their services reduced.	treatment or in restrictive settings longer than necessary. We will be seeking stakeholder input once the risk assessments are completed and the protocol is drafted.
Karen Topper	**79.**	Number of people in public safety have left services. Any follow-up on these people no longer in services? Have they re-offended? Give us names of people and we will check out.	We don't have the total number of people in public safety group who have left services. However, twelve people have been discharged from Act 248 status from 2000-2009. Six of the 12 still receive services, three left the state, two died, and one of found not to have a developmental disability.
Karen Topper	**80.**	Did you know that the people making decisions about DDS have local standing committees giving feedback? Because feedback is given through local self advocates to agencies, self-advocates feel listened to and well-informed.	Comment noted.
	81.	How are the assessments being conducted? For example, are they limited to record review, and for what period of time?	The DAIL Public Safety Risk Assessments are conducted mostly through records reviews. Here is proposed time frame and process the Public Safety Risk Assessment. By the end of December - DAIL contractors will facilitate helping agency staff gather any information missing from the DAIL Public Safety Risk Assessment Worksheets. They will write a draft DAIL Public Safety Risk Assessment for each individual in the Public Safety Group who is served by the contractor's assigned DS agencies. By February - Heather Allin and Robert McGrath will review and finalize each DAIL Public Safety Risk Assessment (approximately 200). They will complete the "Summary and Conclusion" section on each DAIL Risk Assessment, which will provide information to assist in determining whether an individual's current level of supervision is reasonable taking into account his or her public safety risk and current developmental disability needs In March – DAIL will analyze the results of the DAIL Public Safety Risk Assessments. DAIL will work with stakeholders to develop a "draft protocol" for evaluating less restrictive placements. By April – DAIL will present the DRAFT product for review to the legislature to determine whether they agree with our proposed next steps.

	82. What are the requirements of professionals doing the assessments. For example, do they need to be licensed mental health practitioners?	The requirement for the professional reviewing al of the DAIL Public Safety Risk Assessments is that they need to be a licensed psychologist. Robert McGrath is a licensed psychologist and he will be reviewing each DAIL Public Safety Risk Assessment.
	83. What will the process be for review and input about the assessments. For example will the person being assessed get a copy of the report, and an opportunity to provide information and request corrections?	The person will get a copy of the DAIL Public Safety Risk Assessment and will be able to request corrections.
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	84. Where are these people? Of the 33, are they under 24 hour supervision?	People are in the community, not a facility and not necessarily under 24 supervision.
	85. Who assumes the risk? Who carries legal and financial liability?	If person is in agency's care and reoffends, the agency is liable.
	86. How do we determine when the risk goes down?	If the person is in treatment for inappropriate sexual behavior, we use pre-and post-testing using the Treatment and Intervention and Progress Scale for Sexual Abusers with Intellectual Disabilities (TIPS-ID). This gives the team a clear picture of how well the client is functioning and successfully managing his risk to reoffend. For those individuals with a history of violence, the team assesses risk by looking at a person's changeable risk factors. Through the Challenges for Change initiative regarding Risk Assessments for individuals in the Public Safety Group, we will determine risk levels for all individuals in the public safety group.
Project 9 - VocRehab	**Creative Workforce Solutions**	
Lynn	**87.** AHS redesign – Why isn't DOL/DET in a more direct way? Don't they have a database we could use?	The Salesforce Customer Relations Management (CRM) system is designed to specifically track the employer outreach activities of the CWS Employment Teams. We had explored the possibility of integrating with the DOL system, but there were considerable challenges with access for the many CWS partners outside of the state IT "firewalls". In addition, the DOL database consists of self-reported employer information, which can be inconsistent. Because the focus of CWS is employer outreach specific to introducing

		candidates with significant barriers to employment (disability, corrections involvement, generational poverty etc), there is a need to track employer outreach, employer willingness to offer progressive employment options (work experiences, On-the-Job Training, job shadows etc), and a system to share these leads with the members of the Employment Team. DOL and Vermont Adult Learning staff working with the ReachUp program will be accessing this system, as will employment staff from Developmental Services, CRT, Refugee Resettlement, Vermont Associates and other programs funded by AHS.
Sarah	**88.** How do we gauge when a fit "is not good" because of skill set vs. disability. Is there a way to track this?	Each employment program will continue to discuss this with consumers and employers. The Salesforce software will <u>not</u> be tracking any consumer information.
	89. Is it harder for more discrimination because client is one to one.	Not sure if I understand the question. Consumers will still be represented by their existing employment programs, they will not be interacting solely with their employer (unless that is their choice).
Janet	**90.** I'm working with mother on Reach Up. The child and father are in services– how much flexibility is there and how many federal restrictions are there?	Each population has unique employment services and guidelines for those services. Consumers interested in employment will be referred to the appropriate employment services, which will be part of the overall CWS structure. In the case of ReachUp participants, there is a ReachUp CWS Employment Team, which determines employment services and supports based on individuals circumstances. The ReachUp Employment Team is connected directly to the larger CWS Employment Team in each community.
Barb	**91.** How many people were part of the data – 48% of "quite a few"?	This question was regarding the data I cited for progressive employment placements in the VR program using ARRA stimulus funds. We've been tracking outcomes for progressive employment (work experiences, job shadows, OJTs) to determine effectiveness. Preliminary results to date show 485 individuals participating, in progressive employment activities, with 110 securing employment. Of those 110 individuals, 78% entered VR services with no earnings, 45% were working 30+ hours per week, 38% were working 10-29 hours per week, and 17% were working less than 10 hours per week. The progressive

		employment options were available for all VR consumers, including individuals served by our DS and CRT partners.
Karen Topper	**92.** This list of people being served are needing long-term support needs, is PBK based solely on the number of people you place or is it also looking at people who need long-term supports?	Performance-Based Contracting was required by the Secretary of AHS for all grants and contracts. For the purposes of VR Grants and contracts, the measures are specific to employment outcomes for individuals being served using VR funding.
Anne Bakeman	**93.** What would happen to supported employment for DDS if they're all being transitioned to competitive employment?	All existing employment programs remain intact. The only purpose of CWS is to ensure that employer outreach is coordinated and that more employment opportunities are shared between members of the Employment Teams. Supported Employment for both DS and CRT consumers does not change, and those employment programs maintain their programmatic integrity. All CWS does is bring them together with other employment programs to coordinate employer outreach, share leads and broaden consumer choice through increased employer engagement by the Business Account Managers, who serve the Employment Team.
	94. What will happen to the kind of personal relationship that the DDS agency has with the people they serve that helps them support people on the job?	As mentioned above, the relationship remains the same.
Marlys	**95.** Is CWS only looking at V-R funded projects or those funded with other funding streams?	CWS is an initiative to coordinate all employment services funded by the Agency of Human Services. Programs include ReachUp, Corrections, Youth in Custody, Refugee Resettlement, Vermont Associates, VR, DS, CRT , JOBS and others.
Marie	**96.** Within the next 2 fiscal years 2M in V-R funding will transition to structured employment – will this have any impact on DS Waiver dollars.	Not sure I understand this question with regard to "structured employment". We are using initial funding to launch CWS and build capacity to serve underserved populations. Over the next two years we will transition funding from this initial "seed" money to funding from the individual programs. VR will continue to fund employment services in both the DS and CRT programs.

	Additional Challenges for Change projects with heavy DAIL participation	
IFS	**Integrated Family Services,** Melissa Bailey, Project Director	http://humanservices.vermont.gov/challenges-for-change
Janet Cramer	**97.** Are the services being coordinated with the DOE?	Member of the larger IFS planning team, specifically Deb Quackenbush. Also we are connecting with other DOE staff to coordinate efforts especially in connection with their Positive Behavioral Supports implementation and the partnerships around Behavioral Interventionist and School Based Clinicians.
Susan Gordon	**98.** Can the contacts for the groups be shared?	Yes. We can get a list of project leads to Brendan and Marybeth to share as well as make sure it's on the web site.
Amy Caffry	**99.** If IFS incorporates all these different groups, how does DAIL/DDAS get to take the savings from their budget? How does the State measure the savings? **Brendan** intent to look at ALL the budgets (AHS/DOE) to determine savings. E.g. Medicaid funding runs across all different services. "How" is for another	Savings will be applied in the most equitable manner possible. All departments are contributing to the over all AHS savings needed.
Jennifer Fitzgerald	**100.** Are there other departments that have advisory boards?	Specific to IFS we have one overarching Advisory Board consisting of parents, consumers, and professional advocates. It is a representative group that was created trying to cover all representative groups. Additionally the Advisory Board is charged with bringing information back to their groups, contacts, or other families they in connect with – share information, gather input/ideas and share back to the state. All departments have one or more advisory group as well. For example the Department of Mental Health has a state standing committee that consists of parents and providers. We are trying to use the IFS advisory as the main source of family feedback but the other groups will play a role as well.
Karen Topper	**101.** How do they address "transition" from children to adult services? It's already difficult with things in one department, how will it improve if it's between more entities.	We all know transitions are difficult in the current configuration of programs therefore we have made sure it remains a focus in the planning process. We are looking at transitions between early childhood (CDD) and the older than 7yo service system as well as the child/youth service systems to adult

		(DAIL/DMH/DCF). Transitions will continue to be an important topic and the design will need to address creating smoother transitions. As this planning moves forward we anticipate by providing earlier intervention, prevention, supports and treatment to reduce the number of individuals needing transitions.
	SEPTEMBER 23, 2010	**Melissa Bailey and Amy Roth, Overview** IFS is an initiative that began several years ago, when then Secretary LaWare asked key leaders to come together and design an integrated response to serving children and families across the agencies 5 departments and 11 divisions that serve children and families. The initial focus was on services for pregnant women and young children 0-6 years old. Although the charge was to look across the 0 to 22 year old age span. This initiative became the umbrella for several challenge for change projects including, but not limited to: - Children's Integrated Services prenatal to 6, - Enhanced Family Treatment services designed to intervene earlier in moderate and intensive needs situations to provide family support and treatment as needed to divert out of home placements and keep families together. - Decrease in the use of and length of stays for inpatient psychiatric hospitalizations and residential - The integration and streamline of state operations to provide integrated services and support to families through VDH-CSHN and DAIL – CPCS, hi-tech programs - Review and ensure best practices in the use of psychiatric medication with children and families - Streamlining intake and assessment and case management services - Universal guidelines for <u>out of home care</u> (DCF, DMH, DAIL) - making sure we have more common criteria and language on permanency Conversation for IFS began well in advance of C4C; driven by the need to provide better to supports to the family as a whole, intervene earlier

		to keep families together, track outcomes rather then "units" and eliminate fragmented and siloed funding. Many initiatives across the agency were moving in this direction: differential response in DCF, Children's Integrated Services, Blueprint, Chronic Care Coordination, DMH work with UVM and others. The genesis of this planning was better outcomes and stronger focus on the family as a whole. Amy: early intervention is another big principle behind this before things get so bad that child needs to be removed. Melissa: I see early Intervention and Prevention as a continuum – not just Early Childhood Amy explained CHASS initiative CPCS and Hi-Tech –in greater depth and mentioned that the Family Advisory Panel has been established for stakeholder input.
Susan Gordon, DAIL Advisory Board Chair	**102.** Transitioning children to adult services – could you explain how IFS is addressing this?	Yes we're thinking about it all along the way: 0-22 It's the same issues for kids going from elem to middle, middle to HS, HS to adult – there's not good planning ahead of time; the handoff is not done as well as it could be. I know DS has some particular challenges around how eligibility is determined for DDS and the transition there.
Amy Caffrey, Parent	**103.** Goal is to get one team together for a child all the way through life	Melissa – yes, trying to figure out all the points of transition. We are exploring various models such as one lead case manager, consistent guidelines and outcome expectations for providers so that a family's experience does not differ by provider and perhaps a team that is able to follow a family for longer than is currently designed Brendan – 11 different funding streams have different requirements. We're trying to streamline within this funding structure. E.g should they have 1 case manager, rather than 1 case manager for each funding stream. We're looking at where the services and needs are similar naturally, and where specialized expertise is needed

Amy	**104.** So who takes over at age 22? Do they fall off a cliff. Is there something to help people in adulthood?	Many of our services are currently available only when a consumer (or their family) has reached a crisis or very severe stage, intervening then requires more intensive services and often with less probability of decreased need overtime. The goal of our efforts is to get individuals/families what they need earlier to gain skills, resource connections, supports that will help lessen the need for intensive interventions later…. If we do a better job to intervene earlier and focus on prevention of more severe problems we should reduce needs long term for some and therefore free up resources for those that will require long term supports. In some cases this will not eliminate the need for supports after 22 but should help to mitigate the intensity of the supports or change the nature of the support. In other situations intervening early will decrease resources needed as adults, so that those adults who need services can get them.
Susan	**105.** How are ages set?	We are conceptualizing the zero to 22 year old age span to follow the Medicaid early periodic diagnosis and treatment (EPSDT) guidelines for children and youth in the Medicaid program.
Kathleen Demeritt , parent	**106.** How does the DOE fit into IFS	We have an IFS Steering Committee meeting that DOE sits on as well as some very specific initiatives (e.g. positive behavioral supports) that we are working on collaboratively. DOE representatives have always been part of the "CRC" an interdisciplinary team at the state that reviews residential placements, that group is engaged in re-thinking how we review services, and at the local level LEA reps sit on the Local Interagency teams. We hope to capitalize on that involvement and work together to create IEP's and family support plans that are complimentary in nature and at the very least not contradictory. We are also working with UVM to look at service and cost overlap or gaps within DOE and AHS funding and service streams.
Kathleen	**107.** Where is the accountability? As a parent it's hard to know where to go?	Agencies funded with AHS funds are accountable to the department that oversees them; you should always feel comfortable contacting that division (DAIL, DMH, DCF, etc) as needed. Additionally, there are grievance and appeals processes at the provider and state level. If you are having trouble accessing support from your Local Int Team, that

		type of concern should be reviewed with the AHS Field Services Director for your region and if necessary referred to SIT for further resolution. Act 264. which governs the LIT operations, is about coordination between providers, not specific services so we need to be careful about what the expectation is for that team
Lila Richardson, DD Law Project	**108.** Is the IFS initiative dealing with EPSDT funding in DHVA, esp. the extra money ($2M) used for BRIDGE and supposed to be used for autism? What workgroups are addressing this? EPSDT is an entitlement and others are not. DHVA needs to be involved.	The "earmark" in the Medicaid budget was for case management and therapies to individuals with DD zero to 22 years old. Up until the point of budget rescissions and subsequent budget shortfalls, the following changes had been made and are on-going: Billing codes were decoupled for well child visits and developmental screening to allow pediatricians to be reimbursed for using a recognized standard screening tool.$380,000 supports this type of billing. OVHA and VDH continue work with UVM/VCHIP for practice improvement and training for developmental screening in primary care offices - $300,000 supports work this. Approximately $800,000 supports DAIL Bridges care coordination to buy capacity across the state relative to 0-22 year olds who are not getting case management through some other means and who need such a service Speech language pathologists were allowed to enroll directly into the Medicaid program and $50,000 supports this increased billing. Work to develop strategies for behavioral and parent support strategies for approximately 700,000 was halted to do budget cuts and recession shortfalls. Our hope is that through reworking how we support families in the context of IFS we can re-introduce this work, albeit with no new money.
Bart Mair, HCRS DD Director	**109.** Is the DS waiver for children part of IFS? Send to DCF and IFS	The Enhanced Family Treatment project is looking at how we can better support families and provide treatment intervention as needed along with other family support services. We know anecdotally, that had some families had DS support earlier, their children never would have entered custody. We need to re-think what we are doing so that those types of situations can be addressed before the trauma and stress that separates a family. DCF is at the table with every other department re-thinking

		the best way to use limited funding, keep families together and children safe. The funding that currently supports children and families through DMH, DCF or DOE avenues does not follow children life long, nor is a guarantee that they will qualify for adult DD services, yet many may still have long term, life long needs. Some of the challenge is thinking about how we bring in additional expertise early on at age 8 so it costs less to serve at age 17 or 25.
Marie Zura, Howard Center, DD Director	**110.** I am SO concerned about this being thrown into the pot	You are being thrown into the **planning process**; your specific concerns should be voiced and discussed during the planning process. We are clear that the design ideas we have today maybe not the same ideas that emerge after the statewide planning processes gets underway. It is clear this is a state and local dialogue for redesign.
Marlys Waller, VT Council of DDMH services	**111.** Are the dollars Lila was talking about still available	Please see above, the recession and budget shortfalls halted work, however we are hoping that the IFS initiatives will re-invigorate the thinking, albeit with less money.
Marlys	**112.** When you talk about DS going into pool of everyone, it raises a lot of concerns. DS has had a really hard time meeting existing need.	Many of the children and families struggling with DS are not served by traditional DS funding streams but are served in the DMH, DCF, and DOE system of care by default.
	113. Historically, when we start lumping people together, DS folks can easily get lost. They are frequently devalued in our world. There is need for serious caution about negative impact on people with long-term needs – they are not the people that will "graduate" off of services described by Melissa.	The DAIL bridge program, less then 2 years old, serves a large number of families as does the AHS early childhood programs and children's personal care. We are trying to reduce the number of doors people need to go through to get services and supports to families earlier. Some individuals within the DD world will not "graduate" off services just as some SED kids will not, nor will some children with life long health or hi-tech needs. But if we get families supports and skills and in some cases treatment earlier we may be able to reduce the level of need long term. Some individuals will make tremendous progress and some will require more services/supports and others will be in the middle. But if we wait until everyone is "bad enough" we will never gain the positive aspects we can with early interventions.

Marlys	**114.** What has been the involvement of Stakeholders for IFS? Everyone at the state level has a different perspective than Families and providers that can have long-term implications.	IFS has established a Consumer/Family Advisory Board and has begun a statewide planning process for the enhanced family treatment project. The week of Sept 20th all 12 local LIT teams met to discuss design elements and options. There were representatives from all around the state (DCF, DS, CMH) and families. We are asking everyone to be a steward of sharing information and gathering reactions/ideas/thoughts. We know families have a different perspective and sometimes the same perspective as providers. We asked the teams that met to come up with ideas on how to get more family participation and continue to work with the family networks statewide to achieve this.
Marie	**115.** As our DAIL Advisory Board, I am saying as a DS provider that you understand the significance of this issue as it relates to DDS DDS is going to need a voice here. The things that Melissa described, DDS is already doing (e.g. universal service plan). Although there are opportunities for better coordination, there is a REAL danger in lumping into one pot. Our clients/kids come in and don't get "treatment" they get services and support – the symbol of word "treatment" reflects that they are not hearing that we are different. Kids in DS who go from children's waiver to	The current DS system of care for children is only available if you meet a funding priority, (for the past decade restricted to the most in crisis and most severe) those processes are not available for children who come through other doors such as DCF, DMH, DOE, VDH and/or do not meet a funding priority. These children almost all "loose" services or "fight" for services when entering adult hood. The current system has not found the answer; it can't be left out of the current re-design discussion either. Investing in children and families early is often far less costly in terms of emotional, physical and financial consequences. We are challenging ourselves and our stakeholders to think about how we can do things differently and perhaps provide family, kin and individuals with support earlier to be more independent for as long as possible.
	116. Adult waiver have a "cliff' in the loss of DOE supports, my fear is that they will lose DS services at the point of adult hood. We need your help to preserve our strengths. They should not be thrown out the window just because of C4C. I feel we should being be giving the cut and move on. DS has been a strength and should not be dismantled. It would be a sin.	There are families dealing with various types of disability services who need treatment supports, those that need support services, those that need skill building and specialized training to care for a loved one and those that need any combination of the above or none at all. No one is naïve to suggest that one size will fit all and that is not what we are trying to achieve.

Jim Couts, DAIL Adv Board	**117.** I'd like to see concrete steps mapped of current service map of transitions from one service group to another.	The IFS concept paper delineates services that provide "invention or support" we have many more AHS services that provide various levels of assistance from cash benefits to prevention. **Unclear what is being asked.**
Kathleen	**118.** The idea of treatment – my son gets bigger but there will be no "cure" – serving him makes it harder when he gets older. I'm am trying to help him to be as independent as possible.	In some cases that is the reality of the situation, in other cases that is not. Some individuals have co-occurring needs and we are trying to develop a system that allows for more flexibility in providing the needed services, supports and treatment rather than you get what you get here and you have to go somewhere else to address another need.
AMH	**Adult Mental Health Redesign** Beth Tanzman, DMH Deputy Commissioner	http://mentalhealth.vermont.gov/c4c
Janet	**119.** Will this involve the ECCP?	Yes, elder care is generally part of the Adult Outpatient Programs and these are well represented by the attendees of this working group
Marie Zura	**120.** Is there a DS provider rep on the committee?	The Council identified representatives for this working group including 2 executive directors. The Council identified Julie Martin for a sub group of the Adult Services on reducing inpatient psychiatric care which has not met. The Adult Services Re-Design group is open to additional participants and the meeting schedule, hand-outs, and summaries are available on the DMH website.
Sue Watson	**121.** If there are estimated target savings for this group?	There are cost savings for reducing use of inpatient care attributed to the OVHA budget and a targeted savings of $420K for better integration of mental health and substance abuse services
	September 23, 2010	**Beth's introduction (**3 handouts) Looking at CRT, Substance Abuse (SA), and AOP across the spectrum to find efficiencies. Connections to DAIL: a) VSH - People who participate in the CRT/SPMI are also CfC eligible too for both programs; b) TBI ; c) DDS - d) nursing home calls Charge is essentially to redesign system (AOP, SA, CRT) to provide access to a broader continuum of mental health services at lower cost

		We're undertaking these steps to accomplish the work: - analysis - redesign - new reimbursement methodology - implement plan by January 1
Marie Zura, DDS Director Howard Center	**122.** Who are the people you are not serving now that you want to start serving?	People with Severe Functional Impairments (SFI) may not be getting enough services, and the requests for out-patient services exceeds capacity. At the same time, there may be some clients who are getting more than they need.
Virgina Renfrew, Adult Day advocate	**123.** On #7 of the legislative "charge" you have integrating "all SA and AMH services" – does that mean outpatient and inpatient?	The charge sounds broad to us – including residential and outpatient. I am less certain about hospitalization, and there is not a lot of hospitalization for substance abuse treatment. Complicating this work is that although the C4C language focuses on DA's, in not all instances are the DAs SA providers
Virginia Renfrew, Adult Day advocate	**124.** Any consideration that SA will be included under DMH	The DAs put forth a proposal that at least $420K could be saved by merging DMH with Div of Alcohol and Substance Abuse Services. The DA s may believe that consolidation would render savings at State level, and there are possible admin savings in clinical record keeping, reporting and conventions around opening and closing cases. We've had several years of grant initiatives integrating services at the local level, but we have been less successful at the State level. We did an experiment of consolidation into a single department under Health for 4 years and we were co-located in Burlington. Co-location gave us easier to meet and see. It was most effective when we worked on grants jointly. In addition to treatment programs, ADAP also has a lot of Prevention Services, these are well seated in the Public Health dept..
Michael Sirotkin, COVE	**125.** Dollar figure associated with the Adult Services redesign charge	No. But specific dollar figures associated with: Improvement in employment outcomes (DAIL, DA, etc) Length of hospitalization (500K) Integration of DMH and SA (840K) ALL in addition to 500K admin simplification for DMH

			2% MH DA reduction 20K bulk purchasing 50K deeming, reduced program reviews TOTAL – reduction to DA network gone is around 7M credited toward the Challenges Target
Michael Sirotkin, COVE	**126.**	What is the interdepartmental DMH DAIL team about?	It's about MOU – TBI, DDS, CFC, DOC/SFI Children's Mental Health on how to serve clients with overlapping needs and who may be difficult to treat..
Marlys Waller, VT Council on DDMH Services	**127.**	I hope we don't forget that access to mental health services has been difficult for DD when they are in crisis and needing to access hospital services	DD clients can absolutely have co-occurring mental illnesses, just as individuals with mental illness can also have TBI or require skilled nursing care. The decision to admit to hospitalization is a clinical/medical decision and is generally used for the very specific purpose of stabilizing an acute mental illness condition.
Marie Zura, DDS Director, Howard Center	**128.**	MOU would be great to organize how we interface with kids services	Defer to Melissa Bailey, Amy Roth
Jackie Majoros, Ombuds	**129.**	Seems it's broader than just moving people to less costly settings. People in nursing homes need to be covered too.	Given that there is a need to provide services to more Vermonters, anywhere you see that we can identify savings could help fund the increased mental health services capacity – we WELCOME ideas about this.. Help us ID where we're spending money with poor outcomes and we'll redeploy it to another need. Brendan – we figured out in working with Jackie; we need to provide access to mental health training to the aging and dd systems to improve care
Laura Pelosi, VT Health Care Association	**130.**	It's great to have an MOU with DMH, We also need to do provider to provider training that is not necessarily a departmental issue	This point is well taken, not all this work can be the sole responsibility of the State to accomplish.
David O'Vitt, DDAS	**131.**	We are looking at creating a process AND resource document through the MOU – support and training to providers needs to be in both directions – we train DMH about DD/Aging needs and	Beth: our providers feel the same way. Underpinning this challenge is that the programmatic boundaries and barriers are too strict. We need to provide services to a broader population. Those of you who work in NH and DS waiver, know that this is really hard. The only way to do it: reduce services to more intensive populations or find efficiencies that can be applied to other underserved

		they train our providers about MH needs.	populations. The Legislature is pushing us culturally and programmatically to serve people who have any Mental Ilness condition and not just those with more severe needs. The State Medicaid Plan, as written, offers a much more limited group of services to out patient clients and does not include rehabilitation supports or case management for example- even though these may be what people need. – The question is: can we expand services to those with less severe needs can we bend the curve on other costs? CRT – serves 3,000 annually AMH – 6,500 annually SA <u>in DA only</u> – 4,500 annually The legislation also identifies reducing the length of stay for psychiatric hospitalization for any Medicaid beneficiary – this is another cohort of people who may not be known to or served by the DA system.
John Pierce, DAIL Adv. Board	**132.**	Given that AHS already missing 41M, and it's very unlikely any of the C4C will achieve that target by June, is there a parallel planning process for what cuts need to be made if target is not met	Some has already been taken - For Admin Savings we took aggressive steps around documentation and reporting simplification and have already reduced DA funding. Psychopharmacology cuts will be taken in DVHA as will reductions in inpatient care. 1% reduction for DS and 2% reduction for MH have already been taken
Amy Caffrey, parent	**133.**	Do you have any ideas of the numbers of people being served by both DAIL and DMH and those falling between the cracks and not getting served.	I haven't looked at the epidemiology of unmet need for instance of elders with anxiety and depression or TBI in Vermont and compared to number we're serving. Brendan: There's a lot of overlap between both systems.
SFI	**Seriously Functionally Impaired** Patrick Flood, AHS Deputy Secretary		
Marie Zura	**134.**	If they are released before they max out their sentence will DOC dollars follow them into the community?	Answer in progress.

Marlys Waller	**135.** Is this population largely within the DDS or CRT group, or are they more often those that "fall between the cracks"?	Answer in progress.
Julie Cunningham	**136.** Where will the funding come from for those who are not currently eligible for DS or CRT	Answer in progress.
Marlys Waller	**137.** Is the funding going to be ongoing or just one-time (e.g. high risk pool)?	Answer in progress.
Barb Prine	**138.** There needs to be ongoing funding for this to work. There also needs to be training for each of the DA/DOC/DMH/DS to know how to understand the challenges of this populations? Many DOC case workers are not aware of dB and why people can't be blamed for what they do.	Answer in progress.
Karen Topper	**139.** Under the ADA, can we provide services for people who aren't dB and then have a criminal record? What about the people who don't have	Answer in progress.
Amy Caffry	**140.** In the cost-saving aspects, it seems there are a lot of things that many have impact on money spent a couple of levels down (health care, insurance, unemployment) … paying families … is anyone counting the indirect expenses of people who leave their jobs and need State benefits, because they are	Answer in progress.
Incentives -LTC	**Incentives for Community Based Care** Patrick Flood, AHS Deputy Secretary	
Marlys Waller	**141.** What do we mean "LTC" – aging systems as alternatives to Nursing homes?	Answer in progress.
Janet Cramer	**142.** I would hope groups would set up systems for transitions for groups that are "too big to fail"	Answer in progress.

	or for ALL systems. **143.** How can we preserve the WHOLE range of agencies look at "transitions" across the age range. **144.** **Brendan –** examples: NH realize how they could do business differently (convert to ERC; creating specialized Units – such as Huntington's Unit; support people who need hospital level of care – such as the Vent Unit in Rutland).	
John Barbour	**145.** It might be that DAIL can meet their challenges by continuing what we're doing. Are we meeting our financial target already?	Answer in progress.
Beth Lanoux	**146.** Get the names of the people who participated in Patrick's group	Answer in progress.
DA Master Grant – DDS, VocRehab	**Reduce paperwork, redundant oversight, and develop performance-based outcomes** Suzanne Santarcangelo, Dir. AHS Healthcare Operations	
Karen Topper	**147.** How much money is attached to these efficiencies?	Answer in progress.
October 14, 2010		
Developmental Disability Services Funding Priorities – Budget Discussion		
	148. Why do the funding priorities have age breakdowns?	We've tried to manage services related to others in the broader systems (education and other services available). Age breakdowns are in the System of Care Plan on the DAIL Website.
	149. Imminent risk of homelessness – how does this manifest?	In different ways. One example: someone who lives with parents and is graduating from high school and without support to live without education supports. This is not the traditional "homelessness" meaning.
	150. Are funding proposals developed with case managers? Who decides whether someone meets the priority?	The funding proposals for new individuals are developed with the agency's intake person based on the results of the Needs Assessment. For individuals already in services, the case manager typically develops the funding proposal. In both situations the individual, guardian, and/or family are involved. The intake person and/or case manager decides if the needs meet a funding

		priority. The proposal is submitted to the local funding committee for review then sent on the Statewide Equity Committee. Both committees also review the proposal to assure the needs meet the funding priority and the funding guidelines are met.
	151. How many people with DD receive home and community based services?	In FY 2009 2,372 people received home and community based ("waiver") services.
	152. How many people are reviewed each month at the State level of Equity Committee?	The average is 25 people per month; 285 reviewed by state committee last year
	153. I always understood System of Care Plan was for MR and another plan will be developed for the autism population.	The Vermont Interagency Autism Plan identifies goals and strategies to address the needs of individuals with autism. The DDS SOCP does address the needs for individuals with autism. Many people with PDD and autism do meet the funding priorities and are funded for services.
	154. Following intake, do people get a decision that says they are not eligible for funding priority and they are getting Flexible Family Funding instead?	Yes, people are notified when they don't meet a funding priority and can appeal. They are placed on an "applicant" list in addition to getting notice. The applicant list is for people who don't meet funding priority.
	155. What is our target? How much are we short?	We are projecting a $1.3M shortfall.
	156. Is the $148M matched money?	Yes. The approximately $148M includes both state and federal funds, and are considered Global Commitment funding. It's the total amount of money available to provide DDS.
	157. The Legislature has allocated more money for public safety this year than last year More money for graduates this year; Underfunded for new caseload by 600K; Tried to help Equity fund in the past – 500K	Comment noted. Clarification: new caseload was not underfunded. The amount we requested was approved. The amount we estimated we would need based on the previous 3 year average was less than the previous fiscal year.
	158. Is DAIL's intention as pool for one pot?	At this time DAIL is considering using high school grad funding more flexibly in combination with equity funds.
	159. I'm concerned that we take money away from those with existing needs and create the extra funds. How often do we review existing budgets?	There is an annual review of each person's support services and funding. The family and service team meets with the individual to determine if needs are being met; if needs can be met with less (or more) services.

	160. Moving money from people who are stable is how we've approached it in the past. So it's thin already – not much margin. I do not think we have that option in many places anymore.	Comment noted.
	161. What is funded for people who are at risk of being homeless? What is the standard?	It may be home supports, it may be community supports or respite to cover the hours the parent are not home. It varies depending on the individual's specific needs.
	162. Is there a protocol for how you cut services? Is it local or state decision? Is it subjective? Is there any weight to relative needs in various agencies?	If we have to do a rescission, the state determines the protocol. For example for the Jan 2009 rescission, DAIL developed a protocol that was used statewide, across all agencies/individuals. For the Challenges for Change 1% reduction, agencies were given flexibility in deciding how to make the reductions. If services need to be reduced, the individual and guardian are involved. It is somewhat subjective but based on information from the person and their team. Provider from HowardCenter explained: We meet with a family and explain what the cut means for each person (e.g. $1500). We look at their current needs and see if we can carve it out or not. We also look at other models of services. For example, can shared living be changed to a roommate model, so it costs less. Or for example, should we change from agency staff to a contracted model? We try to look at how to meet the need of person with least impact. Provider from Upper Valley Services explained: Everyone has an individual budget. Agencies are given an equal reduction (e.g., 1%) ; the amount is based on their overall budget. We equalize this agency by agency and by level of funding.
	163. Are we just talking about the 800K trying to be saved? Are you talking about suspension of other priorities? Suspending certain services?	We are estimating a total shortfall of approximately $1.3M. We are in the planning stage of deciding the tools to manage the shortfall (e.g., suspension of priorities is one tool). We invite your input.
	164. What happens when someone is eligible? Does someone make a pitch that a person meets one of the funding	We have a standardized needs assessment process. The agency and guardian complete this along with the individual.

	priorities?	
	165. I have a bias against stopping certain services wholesale because it takes the flexibility away. I trust the local persons to make the decisions because they know the needs better.	Comment noted.